11693556

Neutral Citation Number: [2009] EWHC 3504 (Fam)
IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION
COURT OF PROTECTION

Royal Courts of Justice
Strand
London WC2A 2LL

Thursday, 15th October, 2009

BEFORE:

MR JUSTICE HEDLEY

BETWEEN:

(1) A NHS TRUST
(2) B PCT

Applicants

-v-

(1) DU
(2) AO
(3) EB
(4) AU

Respondents

MR S CHAWATAMA (instructed by Capsticks) appeared on behalf of the Applicants.
MR P PATEL (instructed by the Official Solicitor) appeared on behalf of the First Respondent.

A P P R O V E D J U D G M E N T

Digital Transcript of Wordwave International, a Merrill Communications Company
101 Finsbury Pavement London EC2A 1ER
Tel No: 020 7422 6131 Fax No: 020 7422 6134
Web: www.merrillcorp.com/mls Email: mlstape@merrillcorp.com
(Official Shorthand Writers to the Court)

No of Folios – 62
No of words – 4424

J U D G M E N T

1. MR JUSTICE HEDLEY: This case concerns a lady known as DU. She is aged 86 and is Nigerian both by ethnicity and citizenship. The applicants in these proceedings are a London teaching hospital and the relevant primary care trust, they having initiated proceedings in the Court of Protection on 13th March 2009. The second to fourth respondents are members of DU's family. The third respondent, AB, has acted in person. She is the daughter of DU. The others have been represented. The fact of the matter is that the relationship between the hospital and primary care trust, on the one hand, and DU's family, on the other, has broken down and that is the reason that this litigation comes about.

2. It is, of course, axiomatic that in the ordinary course of events the treatment of a patient who lacks capacity will be dealt with by agreement between the treating team and the patient's family and nothing that I say or order is designed to prevent the implementation of any such future agreement. But, of course, where relationships have broken down, although agreement may still be possible, the court, as it were, provides for a default position which, in the absence of agreement, the parties are required to comply with.

3. Because of the nature of the matters that I am asked to resolve, the reasons for the breakdown in the relationship are not relevant and I have not permitted the investigation of those matters, though there have been occasional allusions to them and one is left with something of a vague picture.

4. Section 2(1) of the Mental Capacity Act 2005 provides as follows:

> For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
>
> (2) It does not matter whether the impairment or disturbance is permanent or temporary."

5. It is, of course, crucial that capacity is assessed on an issue by issue basis, but the medical evidence in this case that DU currently lacks capacity to make any decision in relation to her medical treatment and care is all one way. Nor indeed has anyone seriously suggested to the contrary, although I am perfectly willing to accept what EB says, namely that there are occasional signs of improvement. It follows from that that the court, having made that finding, is vested with jurisdiction under the 2005 Act.

6. The principles on which the court should act are set out in section 1, and the material subsections are (5) and (6), which provide as follows:

> "(5) An act done, or decision made, under this Act for or on

behalf of a person who lacks capacity must be done, or made, in his best interests.

(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."

Subsection (5), the "best interests" section, is self-explanatory and reflects the longstanding practice of the High Court in dealing with persons who lack capacity. Subsection (6) is, as it were, the injunction to least intervention, the purpose of which is to recognise and protect the article 8 rights of any person who lacks capacity.

7. The problem in this case has arisen initially over a dispute between the treating team and the family as to whether DU should have inserted a percutaneous endoscopic tube known as a "PEG", or whether she should continue to be treated and fed and hydrated through a nasal gastric tube.

8. In order to understand that dispute and the matters that are associated with it, it is necessary to know something very briefly of the background of DU. As I indicated, she is a lady of some 86 years and self-evidently in extremely poor health. She comes from a distinguished Nigerian family. It appears that apart from a period of study in the United Kingdom in the 1950s she has essentially lived her life in Nigeria, though being a not infrequent visitor to this country in respect of holidays and the like. The greater part of her family resides in Nigeria, either in Lagos or Another City, although EB has always lived in this country, though now in fact is resident in Germany. DU came to this country in 2006 for the purposes of a family wedding, but during that visit she was taken ill and in December 2007 suffered a transient ischemic attack and, consequently, a serious stroke, which has left her seriously disabled. In particular, she is unable to swallow and is unable conventionally to communicate. She requires 24-hour care and she also suffers by way of complication from diabetes and hypertension. She was admitted to the hospital in October 2008 and has remained there since, although it is common ground that she has for a long time now (at least 9 months and possibly longer) been clinically stable and able to be discharged into a suitable community placement, were one to be available. She has throughout, as I have indicated, received hydration, nutrition and medication where necessary through a nasal-gastric tube. As a general rule, the evidence demonstrates that nursing homes and care establishments which would otherwise be equipped to accommodate a lady in DU's condition normally require as a condition of admission the insertion of a PEG for the purposes of hydration, nutrition and medication. The reasons for that will become apparent in due course.

9. The matter proceeded in the Court of Protection in Archway. There came a time when the proceedings were transferred to the High Court, and they came before me yesterday. It became apparent, as indeed was evident from some of the pre-hearing documents, that there was an issue that needed to be considered before the medical issue, namely whether or not this lady should be

returned to Nigeria. The indications were that that could be done in a period of six to eight weeks or so. For reasons that will become evident, that is an issue that needs to be resolved before the issues either of medical treatment or of placement are considered and, accordingly, the questions which the court is required to resolve are these. First, should DU be returned to Nigeria? In principle that is now uncontroversial. Secondly, if she should be returned to Nigeria, under what circumstances should that be done? Again, that is not controversial save perhaps as to some details. Thirdly, if she is to be returned to Nigeria, should she have a PEG inserted before doing so? It is common ground that that would not be essential and in these circumstances not desirable either. Fourthly, if she is to go to Nigeria, where should she reside between today and the date of travel? Should she remain in hospital, or should she be transferred to a nursing home? That is potentially controversial. If she either is not or cannot be returned to Nigeria, then two further questions arise: fifthly, should she have a PEG inserted (something which is controversial) and, if she should and does, where should she then reside (something that may not be controversial if the other matters have already been dealt with)?

10. This case illustrates the breadth of the concept of best interests which the court is bound to apply. The focus of the case was very much on treatment and where she should be. But, of course, the introduction of the possibility of Nigeria adds a new dimension. It is an integral part of the concept of best interests when dealing with a person of this age that the court recognises the imminent possibility of death and the importance of making arrangements so as to secure that the experience of death may be in a context which is the most congenial and peaceful that can be devised. Also implicit in the concept of best interests is the importance of the country and culture of origin and the whereabouts of the family. They will often take precedence over, for example, the question of risk avoidance or the exact quality of care that may be available. It is not possible to travel without some incidence of risk, but that is a risk that may be easily outweighed by the benefits of successful travel. It may be the case, insofar as it is remotely the business of the court to investigate it, that the quality of care at the point of destination may not be the same as the quality of care at the point of departure. Those are matters also which may easily be overcome by the benefits of relocation, and it is in consideration of those matters that the question in principle of this lady's transfer back to Nigeria is no longer controversial. It is clearly in her interests, having regard to her condition, her background and the whereabouts of her family, that she should if possible be transferred to Nigeria, and the evidence suggests that that is probably practicable.

11. In those circumstances, the applicant hospital and trust does not at this stage seek an actual order in respect of the insertion of a PEG, even though it so happens that the court has listened to the evidence in relation to that matter. The reason that an order is not sought, and in my view correctly not sought, is that the question of a PEG need only arise if either the return is not actually arranged or transpires to be impracticable. But were the situation to arise where this lady was to remain, for whatever reason, in the United Kingdom, the court has heard the evidence in relation to a PEG. The court heard oral evidence from Dr X and Dr Y and from EB in respect of these matters. There

was, of course, written evidence as well, both from the family in support of the position taken by EB and of a medical nature in support of the position adopted by the medical expert witnesses.

12. The essence of the medical evidence was that, in circumstances such as these, the insertion of a PEG would be wholly conventional treatment. It is easy to fix with only a small clinical risk involved in so doing, since a general anaesthetic is not necessary, and indeed having regard to the present state of DU nothing other than a local anaesthetic would be required. Secondly, a PEG is easy to use and the staff of nursing homes or care homes equipped to deal with a lady in this condition are conventionally familiar with the use of a PEG. Thirdly, provided it has been in situ for four or so weeks, a PEG is easy to remove and the removal of it carries with it only the smallest of risks. On the other hand, so the medical evidence discloses, there are certain disadvantages with the nasal gastric tube. It is, by definition, uncomfortable simply because of the way in which it runs. Secondly, there are risks that it will come out wholly fortuitously in the course of ordinary events and without necessarily any carelessness on the part of any carer. If it comes out, not only does it have to be re-fixed with the necessary physical inconveniences involved for the patient, but it requires an admission to an accident and emergency department because it cannot be satisfactorily re-fixed unless the position of the tube is checked by x-ray so as to ensure it is correctly positioned. And, says the medical evidence in this case, when you add together the advantages of the PEG and the disadvantages of the nasal gastric tube, it is evident to see why this is now regarded as a conventional treatment, and should it be desired to discharge DU from hospital to a care home, as it very much would be, then it is at the very least highly desirable and in most cases wholly essential that a PEG has been fitted. It is, however, resisted on two grounds: one general and one more particular to this family. The general ground on which it is resisted is a cultural objection to operative treatment which is not strictly necessary and a preference for favouring non-operative interventions where they can be used to achieve the same result. The second, more specific, ground is that the family as a whole are opposed to the insertion of a PEG in the case of DU because such a procedure was undertaken with DU's husband and he died within some six months of that event. And, of course, those matters in the minds of the family associated and coupled with the innate cultural objections provide grounds for opposition to the unanimous testimony of the medical evidence.

13. A further factor should be mentioned which is of some importance in this case. It emerged from the oral evidence of Dr Akinkumni. It was apparent in his written evidence, but it emerged from his oral evidence with particular clarity. Dr Akinkumni is in fact a consultant forensic psychiatrist practising in the United Kingdom, but he trained in Nigeria in general medicine and indeed continues to be a visiting lecturer to the teaching hospital in Lagos and, therefore, retains current familiarity with what one might describe as the medical landscape in Nigeria. He also took the trouble to communicate directly with the deputy clinical director of the private hospital that the family had in mind as being the appropriate place in which their mother could be cared for. Dr Akinkumni made it clear that conventionally in Nigeria a PEG

would not be used, but a nasal gastric tube would be. He gave what, in my view, were sound reasons why that should be so, reasons which perhaps do not necessarily need to be set out in this judgment, but nevertheless were, so far as he was concerned and the Nigerian medical authorities were concerned, compelling reasons why one might try to manage someone on a nasal gastric tube. It is accepted that, although that is a less desirable approach, it is nevertheless practicable.

14. It follows, therefore, that if this lady is to be returned to Nigeria there are good reasons why a PEG should not be fitted, although of course it could be because it could be fitted and removed, but, in my judgment, if this lady stays in the United Kingdom on an indefinite basis, then there are very compelling reasons why, in principle, a PEG should be fitted rather than persisting with the nasal gastric tube. The reasons really are those expressed within the medical evidence, not just because that is the conventional treatment and because it is usually a condition of admission to a care home, but because it would be disruptive for this lady in respect of whom the NGT has been dislodged on several occasions to be required to be admitted from time to time to a public accident and emergency hospital for the purposes of re-fixing it. And, in the absence of fresh compelling medical evidence to the contrary, it would be, I think, extremely difficult to persuade this court, in the event that she remains in this country, not to declare and authorise that her best interests would be served by the insertion of a PEG. But, of course, it would be unnecessary to do that at the present time because, as I say, if she is to be transferred to Nigeria within a relatively short timescale there are perfectly sensible reasons why a PEG should not be required in the interim period.

15. It is important to emphasise that, in relation to preparing for a return to Nigeria, the responsibility rests principally upon the family to act and to make the necessary arrangements. I have not investigated the background to this, but it is clearly the case that return to Nigeria has been on the agenda for some while and that nothing very much has happened. As I say, it is not helpful nor necessary for me to investigate why that may have happened, but it is important to emphasise that the responsibility for the arranging of such a transfer lies in terms of initiation with the family themselves. It is apparent that a receiving hospital in Nigeria will, of course, require proper medical information about the condition of DU. It is no doubt the case that any registered medical practitioner in Nigeria deputed to escort DU back to Nigeria will also require the same information. The hospital, of course, have duties as to the disclosure of confidential information about patients, but they should be entirely free to disclose to a registered medical practitioner in Nigeria acting on the authority of the family the information necessary for them to assess whether they are able to care for DU, on the one hand, or to undertake the responsibility for escorting her in transit, on the other. And it would be helpful if the order consequent on this judgment contains a recital to that effect.

16. There will also be two assessments that will need to be undertaken in the immediate future. The first relates to a possible nursing home, and that is a procedure with which this particular teaching hospital will be well familiar.

Secondly, there will need to be an assessment of whether or not this lady can travel to Nigeria on a commercial flight and, if so, what conditions will have to be fulfilled and what facilities will be required in order to enable her to do so. That may involve a visit from the proposed medical escort; it will almost certainly involve providing the proposed carrier with sufficient information for access to the patient for them to be able to make their own assessment of what can be done. It has been indicated to me on behalf of the applicants that facilitating of those matters is, of course, accepted, and it may be helpful if again those matters are dealt with in the recital. I do, however, stress that letters from the family and letters from the solicitors of themselves will not be enough. It is almost certainly the case that the hospital will require requests from registered medical practitioners acting on the instructions of the family or the carrier, as the case may be, for the disclosure of such information, and such requests may in my view be properly accommodated without any risk of breach of their duties of confidentiality.

17. Although this cannot perhaps appear in an order at this stage, I think it desirable that I say something about the transfer of responsibilities so far as DU is concerned should she be transferred to Nigeria. As I have indicated, the obligation is on the family to make the arrangements. They have observed that she will need to be escorted by a registered medical practitioner who will himself or herself require the assistance of at least one and perhaps two trained assistants, whether nurses or paramedics. No doubt the carrier will actually have requirements of their own as well. It seems to me that the applicants' responsibilities so far as this are concerned are twofold: first, to satisfy themselves that travel in the manner indicated is practicable, i.e. that the carrier's conditions can be fulfilled without serious prejudice to the health of DU; and, secondly, once DU leaves the hospital premises escorted by a registered medical practitioner from Nigeria with a qualified assistant as the first stage in the fulfilment of those travel plans, the responsibilities of the applicants really come to an end. It is greatly to be hoped that within the timescale indicated, namely six to eight weeks, these arrangements can be effected and carried out. It is essential that they are done so, because EB says that she herself is travelling to Nigeria at the end of that period and if DU is left behind it is almost certain that she will have to be treated as someone who is going to remain indefinitely in the United Kingdom, and there are accordingly pressing reasons why all these matters should be attended to within the timescales that have been confidently given to me.

18. That leaves the issue about where DU should stay in the interim. As I say, that decision first and foremost is one that should be arrived at by agreement between the hospital and the family, and one of the reasons that I have indicated that an early assessment by the care home indicated by EB should be permitted is to ensure that such negotiations can take place expeditiously and in good faith between the parties. If agreement is reached, that takes precedence over any views which the court is now going to express, because those views indicate a default position on the basis of an absence of agreement.

19. If there is no agreement, what are the principles on which the court makes a

decision about the interim residence of DU? It is really a question of what do I think are the most pressing matters in her best interests, and they are these. First, the need for speedy decision making and carrying into effect of the transfer to Nigeria without any other matters getting in the way of it. Secondly, there should be nothing which interferes with, or retards that progress, or in some way sends mixed messages to DU (insofar as she is able to absorb indirect messages, as she may very well be able to do). But the court must also recognise that she is in fact fit for discharge from hospital and the court must also recognise that there has been a breakdown in relationships between the family and the hospital, and I record with a slight degree of unhappiness that in the exchanges in the witness box between Dr X and EB such breakdown was readily apparent. I also need to bear in mind that, of course, the hospital retain a close involvement in the arrangements for the move to Nigeria because, of course, they are the possessors of the crucial information upon which many of the arrangements will have to be made.

20. It will be readily apparent to anyone who has listened to the evidence in this case that those principles do not all pull in the same direction. Some favour one approach, some favour the other, and they do not produce an immediate solution to the problem. As I have indicated, I would wish the parties to reach agreement on this, but, if they cannot do so, then it is my view that DU should remain where she is whilst the necessary arrangements are made. Quite simply, it is because such matters are least disruptive to DU, particularly if an NGT falls out, and, secondly, that the hospital are going to be closely involved in the arrangements for her discharge, and they are likely more quickly, more efficiently to be made if DU remains there. Although it is no reason to justify my decision, such a decision would have the beneficent sidewind consequence that there would be no other priorities in the family programme other than to arrange and carry into effect the move to Nigeria.

21. How is all this to be recorded in an order of the court? There will clearly have to be the conventional declarations as to incapacity. I think it desirable that the order should record a best interests decision that DU should be permitted to return to Nigeria subject to the making of practicable arrangements. To cope with the interim position paragraph 8 of the current order will have to remain in force in terms of her whereabouts. It is not necessary for the order to record my views as between nasal gastric tubes and the PEG, but those views I have expressed in the judgment so that everybody may know where we start from. Those views, of course, stand suspended for so long as the arrangements are put in hand to effect a transfer to Nigeria. But I thought it right that the parties should know what my longer term views are in the event that no such transfer is arranged or turns out to be, for one reason or another, impracticable.

22. There should, of course, be liberty to restore this matter at short notice. The matter will be reserved to me. I shall hear what the parties have to say, if anything, about the provision of a transcript of this judgment and of its dissemination, if so agreed.

23. I do not think this is a case in which it would be proper to make any order for costs in relation to the family's participation in this matter. I make it clear that

that is the conventional approach of the Court of Protection in welfare cases, but, of course, if in future there were proceedings which were provoked by the unreasonable behaviour of any party in these proceedings, the court retains the power to mark its displeasure of any such behaviour by making adverse orders as to costs. It is a power rarely exercised but one which the court retains. Whether there is an issue as to costs between the applicants and the Official Solicitor is a separate matter on which I am willing to hear submissions.

24. That is the judgment I propose to give, and I am willing to hear any submissions anyone now wishes to make about the form or substance of the order.

_____